Group Proxy Calculation

Idaho Medicaid Electronic Health Record (EHR) Incentive Program

June 2012

Note to Providers: There is a good possibility that business processes will change after the program is launched. Potential efficiencies as well as potential problems are likely to become evident. This paper describes the business as of spring 2012. Please be sure to return to the information on the website and in the provider handbook often for updates. Creation dates will be noted on each paper.

Introduction

Patient volume thresholds must be established each year a provider applies for an incentive payment. Patient volume is based on a consecutive 90-day period (calendar days) from the previous calendar year (Jan-Dec). Eligible professionals (EPs) may attest to patient volume using the individual patient volume calculation or the group proxy patient volume calculation in any participation year. Group proxy may be completed at the clinic level or at the organizational level. This paper provides information on using a group proxy calculation only.

Group Proxy Calculation Defined

The Centers for Medicare and Medicaid Services (CMS) is allowing a group level patient volume calculation. This proxy can be used by providers who are basing their patient volume calculations on Medicaid encounters and by providers who are basing them on needy individual encounters. There are certain conditions, defined by CMS and Idaho Medicaid, that apply**:**

- The clinic or group practice must use the entire clinic's or group practice's patient encounters and cannot limit it in any way. Any proxy level patient volume calculation must include the encounters of ALL practitioners, both eligible and non-eligible. Eligible professionals are physicians, nurse practitioners, dentists, certified nurse midwives, and physician assistants. Non-eligible practitioners may include physical therapists, social workers, etc.

- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

- The clinic's or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional. The professional must provide services to either Medicaid patients or, if in an RHC or FQHC, to needy patients.

- There is an auditable data source supporting the clinic's or group practice's patient volume.

- All eligible professionals in the group practice or clinic must use the same methodology for the payment year.

Group Proxy Level – Organization or Clinic

The group proxy calculation can be set at the organization level or the clinic level. If using an organization level proxy calculation, the clinics that are included cannot be an arbitrary group of clinics to maximize patient volumes. An organization level proxy must include all of the organization's clinics that are within the state of Idaho. **No out-of-state clinics will be allowed to be included in the proxy.**

Documenting a Proxy Calculation

The Idaho Medicaid EHR Incentive Program has developed a group proxy calculation worksheet to help facilitate consistent attestation of patient volumes by eligible professionals and to streamline patient volume verification. After the group proxy calculation worksheet is completed it needs to be converted to a PDF format and submitted during application/attestation in the Idaho Incentive Management System (IIMS).

Using the Group Proxy Calculation Worksheet

- The entity responsible for the group must complete a group proxy calculation worksheet and make it available to all eligible professionals.
- Every eligible professional must attach a copy of the group proxy calculation worksheet and its supporting patient encounter report during the application/attestation process for the Idaho Incentive Management System (IIMS).
  note: the 90-day patent encounter report of needy/total patient encounters is required to support the proxy calculation.
- A NEW group proxy calculation worksheet must be completed every year the group's eligible professionals apply for a Medicaid incentive if using the group proxy calculation approach that year.

Frequently Asked Questions

What worksheet should be used?

There are two different group proxy calculation worksheets available depending on what setting the eligible professional is working in as shown below:

If you work in an…	Your patient volume can be based on…	Group Proxy Calculation Worksheet to use…
FQHC, RHC, or Tribal Clinic	Either needy or Medicaid	Proxy Based on Needy Encounters or the Proxy Based on Medicaid Encounters
Other facility	Medicaid	Proxy Based on Medicaid Encounters

Is using a proxy required?

The Medicaid EHR Incentive Program does not require an EP to use one method of patient volume calculation over the other. All EPs are free to use an individual patient volume calculation or a group proxy calculation. All EPs are encouraged to talk with their clinic's/organization's administration as they may have a preference.

What's the best way to establish a group approach?

All EPs enrolling in the Medicaid EHR Incentive Program from a clinic/organization must use the same approach for any given calendar year to meet patient volume requirements. The **first provider approved for payment will set the approach for the clinic/organization**. For example:

- If the first provider enrolling from a clinic/organization attests to individual patient volumes (and is approved for payment), all providers subsequently enrolling for that calendar year from that clinic/organization will be required to attest to individual patient volumes and are not allowed to use a proxy at either the organization or clinic level.
- If the first provider enrolling from a clinic/organization attests to the group proxy calculation for the clinic/organization, subsequent providers associated with that clinic/organization will be required to attest to the same overall patient volumes using the same group proxy worksheet. They will not be given the opportunity to use individual patient volumes.

Is there an example of a group proxy calculation?

The following excerpt from the CMS FAQ# 10362 illustrates how the group proxy calculation is to be applied.

If an eligible professional in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual eligible professional (EP), how should a clinic or group practice account for EPs practicing with us part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all eligible professionals practicing in Clinic A, this would not preclude the part-time eligible professional from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an eligible professional would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy

patient volume. However, such eligible professional's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the eligible professional could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all eligible professionals in the group practice or clinic to use the same methodology for the payment year) was to ensure against eligible professionals within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume eligible professionals from applying using their individual patient volume, where the lower Medicaid patient volume eligible professionals then use the clinic volume, which would of course be inflated for these lower-volume eligible professionals.

CLINIC A (with a fictional eligible professional and provider type)

- EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
- EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Additional Information

For questions about this or other issues concerning the Idaho EHR Incentive Program, please go to www.MedicaidEHR.dhw.idaho.gov. There you will find an “Ask the Program” feature that will allow you to send questions to program staff. You can also call the Idaho Medicaid EHR Program Helpdesk at (208) 332-7989.